Facing competing cultures of breastfeeding: the experience of HIV-positive women in Burkina Faso

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Abstract

In low-resource areas of West Africa where infant feeding patterns are dominated by prolonged breastfeeding, the prevention of mother-to-child HIV transmission requires new feeding practices: formula feeding or exclusive breastfeeding limited to six months followed by rapid weaning. Both patterns are innovations for the majority of women in all social categories at the local level. As innovations, these practices are applied only under certain conditions met by mothers; they also have social consequences. Two ethnographic studies conducted in 1998-2000 and in 2003-2007 explored women's perceptions about "good infant feeding" with implications for "good mothering," and the social relationships that are involved in infant feeding management in a setting shaped by patrilinear organization. These studies also show the contradictions that HIV-positive women face in two local sub-cultures of breastfeeding: the one involving the baby's father, the family and neighborhood, and the other involving health services and PLHIV support organizations. Women must rely on a range of strategies to face difficulties related to the lack of economic or social autonomy or support from the child's father, the risk of stigma, social norms regarding breastfeeding and contradictory discourses among health workers. HIV-positive mothers' experiences bring to light several key features of local infant feeding cultures, including the changes that occurred over the last ten years regarding the fathers' role, the impact of infant feeding conceptualization in biomedical institutions and the promotion of a model of infant care based on the dual mother-and-child relationship. These dimensions are considered in relation to general social trends in a West-African society regarding women's autonomy, the role of the couple in the household and the medicalization of infant feeding.

Keywords

Burkina Faso, Africa, infant feeding, HIV, local cultures, women's strategies, social change

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1. Introduction

It is commonly assumed that in all societies the HIV pandemic has revealed and transformed social practices and their symbolic underlying logics. Its dimension of revelation is related to the link between HIV modes of transmission and the circulation of biological fluids among individuals: HIV management gives public exposure to practices that are usually intimate or hidden. It also appears when epidemiological discrepancies in HIV prevalence rates among populations reveal underlying structural inequities. Its dimension of transformation is related, among other aspects, to the extent of the epidemic's social and cultural impact and the public health measures to fight it, with consequences at micro- and macro-social levels. Which significations might these notions hold regarding infant feeding practices in West Africa: were these practices or related norms, perceptions, social roles and relationships revealed or transformed by HIV?

Despite high numbers (several hundred thousand infants becoming HIV-positive every year in Africa due to transmission through breastfeeding),[3] it was only at the end of the 1990s[4] that this issue became a worldwide public concern beyond specialists' circles, when UN agencies published a policy (WHO/UNAIDS/UNICEF 1998). Until then, several factors had hindered the definition of preventive strategies, including the lack of easily available and low cost technical measures and the difficulty in implementing measures that could fit in with varied social, economic, educational and material environments, when all HIV-positive women had turned to replacement feeding in developed countries. Other factors included concerns about the spread of formula feeding in resource-poor settings (see chapter XX by Thairu) and the conceptual and organizational difficulty for health agencies that promoted breastfeeding as a healthy behavior when considering HIV transmission (Desclaux 2000). This situation of "secrecy and ignorance" about HIV transmission through breastfeeding and consequences regarding pediatric AIDS, while other aspects of the pandemic such as HIV sexual transmission and clinical aspects of AIDS in adults were fully acknowledged at the public level, had a particular effect on the course of HIV/AIDS public policies regarding this mode of transmission, that first prevented any "revelation" or "transformation."

Over the next 11 years,[5] strategies proposed in 1998 were implemented, promoting particular infant feeding practices among HIV-positive women—exclusive breastfeeding with

[3] The first estimates of global figures for Africa by UN agencies remained unpublished until the 2000s.

[4] This was 17 years after the identification of HIV and 8 years after the quantification of HIV transmission through breastfeeding in Africa.

[5] New recommendations have been published in November 2009 that, using antiretroviral treatments, propose that norms regarding infant feeding pattern for all HIV-positive mothers be defined at the national level, choosing between exclusive prolonged breastfeeding or replacement feeding (WHO 2009).

early weaning[6] or replacement feeding—that fit in with local norms and habits among general populations. The decision to implement one of these two feeding patterns was "left" to women, and should have resulted from an interaction with health workers during counseling sessions before the infant's birth. In this era of "HIV particularism," health administrations were requested to set vertical programs for Prevention of Mother-to-Child Transmission of HIV (PMTCT), responsible for making prevention available and sustainable for all women at an individual level. In countries where preventive infant feeding options did not fit in with local habits, HIV-positive women were supposed to adopt "new" patterns recommended by the health system. Their experiences at this intersection between two sets of norms would depend on the nature and extent of divergences between locally- and medically-defined feeding patterns, the adaptability of each pattern to the local environment, the meanings conveyed by "new" feeding patterns at the local level and the social consequences of adopting particular feeding patterns.

This era of "HIV particularism" may end, replaced by an era of "normalization" when recent WHO recommendations will be implemented, since they request HIV-positive mothers to use preventive antiretroviral treatment and apply an infant feeding pattern defined at the national level. HIV-positive women's experience regarding infant feeding choice and implementation in the 2000s may remain unique. Though public health studies mostly assessed them through successes or failures in achieving safe practices, these experiences may be considered as experiments of a social innovation, revealing the capacity for change and underlying deep cultural trends in social contexts. Was this innovation endorsed in West Africa? What do HIV-positive women's experiences reveal about the local and medical cultures of infant feeding? Has the HIV epidemic jeopardized local cultures of infant feeding and brought about changes, opposition or resistance in practices, meanings or discourses?

Burkina Faso is a particularly relevant site to study these issues. There, prolonged breastfeeding is applied by most women and is hardly ever "exclusive."[7] The HIV prevalence rate was 8.5% among adults at the beginning of the 2000s, which meant that the epidemic was "generalized" beyond vulnerable groups and every family had had or was related to a person living with HIV or an "AIDS case."[8] In Burkina Faso, WHO recommendations proposed that a very high percentage of women known to be HIV-positive adopt infant feeding practices that differed from local habits; the recommendations also outlined that feeding patterns should be defined based on each individual woman's decision.

Transformations in infant feeding were experienced by HIV-positive women at the intersection of two "sub-cultures"—defined as systems of values, beliefs and behaviors associated with a social group: (1) the local culture of infant feeding related to infant care provision and perceptions of motherhood in a multiethnic, mostly patrilinear society with

[6] Categories for breastfeeding practices, which have different rates for HIV transmission, include: exclusive breastfeeding, predominant breastfeeding, complementary feeding, breastfeeding, and bottle-feeding (WHO 2008, p. 4).

[7] Some 85% of children are still breastfed at the age of 20–23 months; 7% are exclusively breastfed at 0–7 months; 50% get complementary food at 6–9 months (DHS 2003).

[8] The prevalence rate among adults at the national level decreased to 2.0% in 2005, mainly because of the deaths of people living with HIV before antiretroviral treatments were accessible and available on a national level.

polygamous households;[9] and (2) the medical culture of health services that implement PMTCT programs based on global biomedical norms, techniques and knowledge. This "entrance" through culture does not mean that we assume that culture explains all women's and health workers' behaviors; on the contrary, the following pages will show that feeding practices are greatly determined by material and economic constraints. However, shifts and resistances experienced by women reveal underlying patterns of roles and relationships, as well as strong beliefs and values regarding infant care, which this chapter intends to analyze.

This analysis is based on a rich amount of empirical data. Between 2003 and 2007 we conducted a research program on social and cultural aspects of prevention of HIV transmission in Burkina Faso, using a comparative approach with four other resource-poor countries (Cameroon, Cambodia, Kenya and Cote d'Ivoire).[10] Investigations used the ethnographic method combining non-structured data collection by immersion in health services and associations supporting people living with HIV, 84 structured interviews with 45 HIV-positive mothers (with infants aged between 1 and 3 months, then again between 6 and 9 months), interviews with 7 health and social workers or NGO members, focus group discussions with the same populations and a 1-month observation and recording of individual and collective counseling sessions. Data collection was implemented in Ouagadougou and Bobo-Dioulasso in public health services applying the national program and in services where a PMTCT program was supported by an NGO, an association or a clinical trial. The results were compared to previous results from a study on infant feeding perceptions, stakeholders and practices in Burkina Faso and Côte d'Ivoire before the AIDS epidemic, in 1998–1999 (Desclaux and Taverne 2000). This enabled us to identify the main trends in perceptions and practices, changes over a five to eight year time span and variations between pilot sites hosting PMTCT programs receiving external support and "ordinary" sites from the national program. It also enabled us to identify common situations across countries and local cultural particularities regarding counseling (Desclaux & Alfieri 2009), interactions between mothers and health workers (Desclaux et al. 2006), roles of fathers and feasibility and acceptability of preventive strategies (Desclaux & Alfieri 2008).

2. The cultural landscape of infant feeding in Burkina Faso in the early 2000s

In the early 2000s, feeding patterns most resembled those described in the 1980s in neighboring Mali (Dettwyler 1987). The population considers prolonged breastfeeding as the best infant feeding pattern for material reasons—to feed infants based on their needs and free of cost—and for social and symbolic reasons—to integrate infants into the kinship and finish forming the persona (Dieterlein 1993). The perpetuation of breastfeeding also results from women's living conditions. With very limited industrialization in Burkina Faso, a "Least

[9] Burkinabe population is multiethnic (64 ethnic groups have been identified by national institutions) with a predominance of Mossi, Bobo, Dioula and Peulh categories. The main religion is Islam, followed by Christianity and African cults.

[10] ANRS 1271 (Social Science) Research Program, conducted by CReCSS (Centre de Recherche Cultures, Santé, Sociétés, JE 2424) Université Paul Cézanne d'Aix-Marseille and funded by Agence Nationale (française) de Recherches sur le Sida et les hépatites virales. For details about ethical approval by the National Ethics Committee, see Desclaux and Alfieri 2009.

Developed Country,"[11] most women do agricultural work and handicrafts or have small business in the informal sector, often as individual entrepreneurs. This situation allows them to keep infants "*au dos*" (keeping them on their backs), while doing their work and breastfeeding at any time; situations of incapacity to breastfeed in the workplace are infrequent.

Infants are breastfed until the mean age of two years: it may be much later, sometimes up to five years, or less if the mother becomes pregnant again. Water and herbal teas are given as early as the first days of life, considered as cleansing or preventive liquids rather than as nutritive; this includes lustral water produced by using water to rinse Koranic verses written on a slate and retaining the water as an "indigenous vaccine." Mothers start giving small pieces of various foods and millet gruel when the infant is three to four months or when teeth appear. This gruel may be enriched with sugar and salt, a piece of smoked fish or an egg, as advised by Mother-and-Child Health Services or elder women. Concentrated or powdered milk is also often added, and this gruel is used until the infant is six or seven months old, progressively becoming the predominant food. Fruits such as bananas or oranges are also given squashed. Infants are weaned rather rapidly when they gain a certain level of autonomy and may receive food from the family dish. However, weaning remains an important stage in local perceptions of infant development and is not considered before the child looks healthy and strong enough.

Infant feeding practices are firstly a matter of inter-generational transmission between women at the household level. The influence of "health education" in Mother-and-Child Health Services is also perceptible in women's words when they explain the advantages of breastfeeding in nutritional terms and when they state that breastfeeding is "the best way to care for one's baby," shifting to normative statements. These perceptions are shaped by the discourses of breastfeeding promotion, which developed in West Africa during the 1990s (Desclaux 2000). Though Burkina Faso was never affected by the extension of formula feeding, programs were developed by UNICEF and the Ministry of Health to promote breastfeeding (Programme Hôpitaux Amis des Bébés, Programme national de promotion de l'allaitement maternel) with the help of a national association (APAIB: Association pour la promotion de l'Alimentation Infantile au Burkina Faso) and an international non-governmental organization based in Ouagadougou (IBFAN-FAN: International Baby Food Action Network-French speaking African Network). APAIB brought together mostly health workers who were also experienced mothers and worked to set up a technical discourse and "best practices" regarding breastfeeding, focusing on feeding positions, duration, mastitis prevention and treatment and exclusive breastfeeding, among other topics. However, besides this attempt to "professionalize" infant feeding care, breastfeeding remains mostly a matter of folk healing and household care. Exclusive breastfeeding was mainly adopted by women who were influenced by health workers—often as friends or relatives—or NGO members.

[11] According to this United Nations categorization, these countries (49 in 2009) meet the following criteria: low income, human resources weakness and economic vulnerability. According to the GPI, Burkina Faso ranked 164 for Gross National Income per capita with 480 USD and ranked 177 for the Human Development Index in 2008 (World Bank, see UNICEF 2007).

Moreover, the social uses of breastfeeding promotion went beyond the limitations of the health system: a growing number of stakeholders felt they had something to say regarding breastfeeding, whenever their discourse was limited to a normative assertion when directing mothers to breastfeed; this was the case for political and religious authorities locally involved in pro-breastfeeding activities, particularly during Breastfeeding World Week (Desclaux 2000). Overall, the promotion of breastfeeding has seldom introduced new concepts,[12] techniques or practices at the community level, but it has introduced notions that converge with local perceptions in favor of breastfeeding and has given breastfeeding a moral content and a strong normative value. These notions put forward biological (nutritional) and social (pro "interaction between mother and infant") advantages and turned breastfeeding into a symbol of "a mother's love"—a notion rooted in a Western cultural understanding of individual relationships in nuclear families. Women combine these notions with body perceptions that are based on local ethnophysiology and the actual inscribing of mother-child relationship into the family, as defined by kinship structures.[13]

Infant feeding practices have undergone recent changes in other aspects. For instance, two decades ago, it was still common to encounter an infant breastfed by a woman who was not his/her biological mother. A classificatory mother in the local kinship system, whether it be a biological grand-mother or a mother's sister, or any woman, might replace the mother by chance if the infant was found crying from hunger or fatigue, or in case of the mother's unavailability for either short or prolonged periods due to illness, absence or disqualification by an ethnomedical diagnosis of insanity. These practices seem to have disappeared in urban settings, except for a few hours after birth when a mother's sister may feed the infant until the mother gets enough milk to do it herself; replacement breastfeeding is now limited to situations of replacement mothering—such as fostering. This evolution seems to result from the influence of health workers that discouraged breastfeeding by women who were not the biological mother, even before the HIV pandemic outbreak—which reinforced this trend.

3. The HIV outbreak: introducing "choice" in infant feeding

The UN agencies' recommendations regarding prevention of HIV transmission through breastfeeding were first applied in Burkina Faso within pilot projects either supported by NGOs or implemented in conjunction with clinical trials. It took a few years to adapt a strategy beyond these sites in an environment that lacked nutritional security and adequate sanitation. In 2000, the National PMTCT program adopted the international recommendations that promoted "informed choice" by women. After undergoing a collective and (at least one) individual counseling session during antenatal visits after her HIV status was disclosed, a woman should opt either for exclusive breastfeeding with early and rapid weaning between four and six months, or for replacement feeding if feasible, accessible, acceptable, sustainable and secure.[14]

[12] For instance those mentioned in footnote 4.

[13] For more information on these aspects see Desclaux & Taverne 2000.

[14] In both cases, psychosocial and nutritional counseling should be provided regularly in post-natal clinics and the woman should get help in non-governmental organizations and associations supporting people living with HIV. In addition, other measures were progressively set up to consider mothers' care for HIV, based on the scaling-up of HIV care and antiretroviral treatment availability.

In practice, many women had the feeling that what was labeled as "choice" by health workers was instead a decision made under constraints, since the cost of formula and its preparation prevented many of them from considering this option. The second main constraint was the social risk due to HIV stigma related to formula feeding, since, as one mother said about people in Bobo-Dioulasso: "They say that all mothers who do not breastfeed are HIV-positive." The ability to "have a choice" depended essentially on the context: an actual "choice" occurred in services supported by an NGO or a research project that could provide long-term material and psychological support to women; in other facilities, women were compelled to turn to exclusive breastfeeding, except those who could get economic support from the child's father. Besides these structural—economic and social—factors, women's changes in infant feeding patterns were also influenced by the way "counseling for infant feeding" was interpreted by health workers. Some of them decided which option would be the best for women, based on their social and economic status. In other health services however, where formula and equipment were provided, women reported discussions with counselors on the advantages and inconveniences of each feeding option. Interviews show that in most cases, women would prefer replacement feeding, since any risk of HIV transmission seems unbearable for a mother to consciously take for her infant. In the "balance of risks," compared to HIV infection, the seriousness of diarrhea or malnutrition related to formula feeding was considered insignificant, since these diseases are common in Burkina Faso and curable.[15]

Observations of counseling sessions and narratives of infant feeding decisions by women showed that fathers were often consulted before the decision, which might involve women's HIV status disclosure. Health workers encouraged this disclosure but it was not always planned and might be unavoidable when a father's suspicion was aroused by unusual discussion about infant feeding, normally a banal infant care practice, or when the father had some knowledge about HIV transmission through breastfeeding and personal reasons to suspect the woman's HIV-positive status. In any case, despite the health system's effort to support a rational decision based on the respective advantages and risks of every feeding option, this "choice under constraints" of an infant feeding option involved relational aspects with a strong emotional content for women who frequently had limited time to plan for their infant feeding decision after they were informed about their own HIV status.

Regarding practices, some women managed to implement formula feeding, mostly in pilot sites and when living with a certain level of social and economic autonomy or education. Many mothers faced difficulties for implementation in their household due to the economic and social constraints mentioned above, particularly in cases of shortages of formula provided by the national program. Contrary to what some health workers had anticipated, exclusive breastfeeding was not easy, due to the discrepancies between this feeding pattern and usual ones, for instance, a mother applying a different one from the one used with a previous child. Among the women we met, many made a "default choice" to breastfeed exclusively, then practiced mixed feeding (giving liquids in addition to breastfeeding). This

[15] However, breastfeeding was sometimes chosen for its contraceptive effects by women who could not access other contraceptive means. The rate of contraceptive coverage in Burkina Faso is low; moreover, access and information about contraception among persons living with HIV, as a component of HIV care, are poorly managed in many countries: it is a concern of UN agencies.

situation[16] resulted from their inability to constantly avoid the introduction of liquids or food other than breastmilk for six months. However, women set up various strategies to comply with recommendations and to hide their unusual "choice" on matters previously managed by family and community "know-how."

4. HIV-positive mothers' strategies in the community

The strategies set up by women to avoid the social consequences of discrepancies between preventive patterns and the local sub-culture of infant feeding are particularly noticeable for three aspects: avoidance of HIV stigma, implementation of "proper" breastfeeding and the relationship with the father. Some mothers invented infant feeding patterns that had not been proposed during counseling but that allowed them to minimize the social risks, the economic cost and the biological risks of HIV transmission while preserving infant health.

Since infant breastfeeding is a common public practice when infants are carried on their mothers' backs until they can walk alone, or even later when they are tired, comments on avoidance of breastfeeding practice may come from the family and kinship, neighborhood, mothers' friends or women encountered in public places like the market, the field or other work places. The use of formula or early weaning may be equivalent to public disclosure about a mother's HIV-infection and arouse interpretations about the woman's ability to be a "good mother." Some mothers would combine options on a sequential mode, applying breastfeeding for a few days or weeks after birth to be acknowledged as a "good mother" and to avoid being labeled as HIV-positive then turning to formula feeding to prevent transmission. This use of breastfeeding as "complementary feeding" was also adopted by mothers who maintained or re-started breastfeeding instead of replacement feeding if formula became unavailable or was provided in quantities perceived as insufficient; it also allowed women to avoid suspicion of being HIV-positive. In both cases, the use of breastfeeding for social reasons was not an easy experience for women who feared HIV transmission, since they felt, as one mother stated: "Every time I feed my baby I tell myself I may be transmitting the virus." Their strategy to reduce the overall proportion of breastfeeding in infant feeding was their interpretation, which was not considered by the PMTCT program.

HIV stigma was especially difficult to avoid for poorer women whose formula was provided by the national program or in pilot sites. In their case, their supposed ability to meet this cost was questioned by the household or neighbors; women had to provide believable reasons for using expensive food instead of free mother's milk. Some of them evoked medical reasons that protected them from being considered HIV-positive: inadequate lactation, a breast pathology such as mastitis, breast cancer, etc., which some health workers helped to put into convincing words.

For many mothers the greatest difficulty was avoiding "herbal teas" considered essential by elder women who have authority on infant care in the household. On that matter as on others, the mother's ability to ignore or contradict elder women, whose expertise should be acknowledged by all young women, depends on her relative status in the household and

[16] Mixed feeding carries the highest level of risk for HIV transmission.

relationship with the infant's father, since an elder woman could easily get a young mother rejected. In that case too, some women managed social and biological risks in a diachronic way: they would start with non-exclusive breastfeeding by letting their mothers-in-law perform ritual bathing on the infant despite the possibility that this includes feeding liquids, then turn to exclusive breastfeeding for the remaining months.

Water is also often given to infants by female relatives or neighbors, for instance as a "greeting present" for a mother and her infant when they visit a household. One way to comply with preventive recommendations according to mothers' emic perceptions is to request that only bottled water be given to their infants, since they consider it purer than other kinds of water.[17] Lastly, the ultimate strategy to avoid confrontation, which was adopted by many women to varying degrees, was to remain secluded with their infants, protecting them from any social contact that could jeopardize the exclusiveness of breastfeeding or lead to criticism and questioning. For this reason, some women avoided being helped by young family housekeeping assistants who usually take care of infants. Others would adopt a less extreme strategy, for instance by returning to their parents' household for a few months where they could more easily limit social contact for their infants.

Regarding fathers' attitudes towards mothers, our study shows a slight change between 1999 and 2007. In initial investigations, mothers generally considered fathers as obstacles to changes in infant feeding practices, since they were reluctant about women's unusual feeding practices except in cases of a medically defined reason. They played an active role in feeding choices for their infants only when mothers were too ill to do so (or were dead) and when family support from women was lacking. At that time, few women disclosed their HIV-status to their partners: in our first study only one-third had told them six months after the infant's birth. Most women feared rejection, when being the first one in the couple to be diagnosed with HIV often meant her being considered as the one who had brought HIV to the couple. In recent interviews, women describe most fathers as supportive or indifferent, which is often interpreted by mothers as tolerance about their HIV-status and perpetuation of ascribed social roles that give mothers full responsibility for infant care. Fewer women than in our previous study (about one-third) maintained secrecy about their HIV-status as a strategy to avoid fathers' adverse reactions. In most cases, they used many precautions when communicating with them: carefully choosing the time to discuss this matter; relying on significant others such as a father's relative to show support or to act as an intermediary; requesting health workers to disclose their HIV-status for them; or using means in the interaction that allowed denial in case of violent reaction—such as using "half words," speaking of HIV-positive persons in general before coming to their own case or using euphemistic words. These aspects are not secondary matters regarding infant feeding, since rejection of a mother by her husband may completely disable her from providing proper and safe care to her infant.

Fathers' attitudes about infant feeding varied, depending on their perceptions of feeding options and their trust in preventive strategies when considering the cost for the household.

[17] There is no epidemiological evidence for the relative safety of bottled water compared to water from other sources regarding the risk of HIV transmission when breastfeeding is no longer exclusive.

The father's own experience with his HIV status, whether denial, ignorance or awareness, and his relationship to the mother will determine whether she must handle things alone or whether he will help her with child care after the disclosure. In some cases she will implement a strategy that also meets the needs of her other children. Recent investigations showed that more fathers supported women in their preventive decisions, which made it easier for mothers to handle questions from their families. This was especially the case when fathers knew that they were HIV-positive themselves. In some cases, fathers shared the decision about infant feeding; they would often be more cautious than women in avoiding any exposure to HIV whatever the benefits of breastfeeding and advice from health workers on that topic may be.

5. HIV-positive mothers' strategies in health services

Contrary to what might be expected, women's interviews showed that their situations were not totally secure to implement preventive infant feeding options in health services settings.

The first reason is related to the institutional organization of the management of infant feeding and HIV issues. Since relevant programs—the program for the promotion of breastfeeding and the AIDS program—are both vertically-designed, and despite the political will to "integrate" them at the local level during the 2000s, their implementation in health services never underwent consistent integration. As a result, the particular needs of HIV-positive women, for instance regarding preventive feeding patterns, were still treated as contradicting and endangering the promotion of breastfeeding. HIV-positive mothers found this to be especially true when they were in Mother-and Child-Health services and confronted by posters claiming that "Breast is Best," even though PMTCT programs were housed in the same services. Women would also receive contradictory messages, for instance between Mother-and-Child Health workers unaware of a mother's HIV-positive status encouraging her to breastfeed as soon and as long as possible, when other health workers assigned to the PMTCT program advised her to do early weaning or replacement feeding. In this case, silence was the most frequently used strategy, whatever the uneasiness generated by the contradictions between health workers' messages.

Women experienced the risk of being labeled as HIV-positive, which has not totally disappeared in health services. Although stigma and rejection are now less common, some health workers still avoid relationships with HIV-positive persons fearing they would not act properly or may breach confidentiality about their HIV status. In maternity wards where health workers considered promotion of breastfeeding as their priority, some women were compelled to reveal their HIV status to defend their withdrawal of colostrum or their refusal to place the infant on the breast immediately after birth. Women sometimes used strategies that could be dangerous for themselves or their babies, as in the case of one woman who only gave water to her baby for three days pretending that she was breastfeeding him, fearing both HIV transmission if she breastfed and being labeled as HIV-positive if she needed formula.

HIV-positive women also create strategies to work around follow-up by health workers. In terms of counseling, follow-up for nutritional purposes might be fairly prescriptive or comprehensive, depending on the health workers' knowledge and experience regarding HIV and counseling. Health workers' attitudes were also different among those who had strong

opinions in favor of breastfeeding and advised it in any situation and others who considered respective HIV-levels of risk and thought that formula was feasible in the local context. There were also differences in discourses between health workers who were “optimistic” about women’s ability to stick to the option she had chosen and those who were “realistic” and considered that each choice might entail challenges in an evolving context. In many cases women were criticized for being unable to apply preventive patterns that were beyond their scope, since this depended on the unpredictable attitudes of persons such as husbands or elder women who had authority in the household. Thus, the easiest strategy to avoid this undeserved treatment was lying to health workers about the feeding pattern used or how it was implemented. Some health workers would respond by using their own strategies to verify the mothers’ statements, observing the infant’s body language in proximity of the breast of a mother who pretended not to breastfeed or by pinching the mother’s nipple to see if she was still breastfeeding after the prescribed weaning date.

As a result of HIV stigmatization, women who feared being identified as HIV-positive also had to set strategies to avoid being seen in HIV-related places such as associations for people living with AIDS, pretending to go to Mother-and-Child Health Services or elsewhere. Yet, women who were supported by an NGO or PLHIV group or by counselors from a research team managed to comply more easily with their chosen feeding option. Material means, free provision of substitutes and equipment and the delivery of more individualized information are not the only factors involved. In the “space of confidentiality” of a support group, they are not compelled, as in health services and at home, to avoid certain subjects or justify their actions. They appreciate the opportunity to talk freely about various psychological and social aspects of HIV infection related to managing relationships with significant others, since these aspects are important for the feasibility of preventive options. They also find more coherent and contextualized discourses regarding infant feeding and HIV than in some health services, where partially different and non-articulated discourses for HIV-positive and HIV-negative mothers are confusing. Yet, many women did not take full advantage of these possibilities when they were unable to justify to their husbands why they were leaving the household for an indisputable medical reason, as is the case for going to health services.

6. Conclusion: The evolving culture of infant feeding in the age of HIV

Women’s experiences and the strategies they must set up to apply preventive feeding patterns reveal several aspects of local cultures that are not exclusively related to either health services or the community.

HIV-positive women who are literate and have a certain level of social and economic autonomy may assert their decision and manage implementing any infant feeding option, including formula feeding, whatever criticisms may arise in either health services or households; this is also the case for women who share the management of HIV with their husbands. This observation, which stresses the importance of personal autonomy or support in the couple, is consistent with observations made about HIV prevention in other settings (Buskens et al. 2007; Leshabari et al. 2007; Hofmann et al. 2009) or for other kinds of challenges in women’s lives, whatever the cultural setting.

Their experiences also show that most women may apply preventive recommendations fully and with ease only when they are alone with their infants. They often are compelled to "maintain distance" from the actors of infant feeding in order to avoid the risk of being labeled as HIV-positive or as a "bad mother." This explains situations of psychological distress among some women who bear these constraints alone in addition to planned isolation. It also reveals to what extent infant feeding is a social behavior, involving several protagonists, many of whom feel they have the legitimacy to define what is good for the infant. On this issue, the HIV pandemic stresses the discrepancy between community and health services, since the international medical culture considers the mother as the infant's sole caretaker who can make "individual choices," and often blames her when she is the victim,[18] which is a consequence of individualizing social problems (see chapter XX by Lee).

The difficulties women face when trying to apply an alternative to breastfeeding or to limit its duration to four to six months reveal not only the normative strength of breastfeeding promotion and popular perceptions, but also their rationales. In health services as well as in the community, biological considerations and precise categorization have little weight compared to the social and symbolic logics in defense of breastfeeding—whatever its mode of implementation according to nutritionists' categories—when a full range of actors under various ideological or social guidance have added an "HIV-free label" value for the mother to its long-standing perceived benefits. This strange ambiguity turns maintaining a mode of HIV-transmission into the sign signaling the absence of contamination and thus challenges communication about health. For this aspect, the HIV pandemic revealed, and maybe in some areas such as Burkina Faso paradoxically reinforced, the symbolic value of breastfeeding. The threat that formula feeding practices would spillover beyond HIV-positive mothers, often evoked by child specialists, never became an empirical concern since formula is a sign of mothers' HIV infection and thus a highly stigmatized behavior.

The mothers' experiences stress the symbolic construction, perceptible in both health discourses and institutional organization, of an opposition between breastfeeding and HIV—two heterogeneous categories. Some health workers still seem to believe, as one public health official said in the late 1990s: "The problem is not breastfeeding, it is HIV-positive mothers."[19] In this context, narrated experiences may be interpreted as the result of the embodiment of global categories with profound symbolic content (considering "good" breastfeeding as opposed to "bad" HIV) for women who may both breastfeed and be infected by HIV. As for conceptualization of breastfeeding which, even in health settings, is still considered under a monothetic category when characterization on a biological basis requires at least four categories,[20] this symbolic opposition, which seems hardly questioned by evidence, appears as a fundamental concept in medical culture.

The range of strategies applied by women to reduce social and biological risks for their infants and themselves is wide. For instance, they would often use several feeding options

[18] The idiom "blaming the victim" coined in the mid-1970s by the sociologist William Ryan was applied in the 1990s by Paul Farmer in the field of AIDS and summarizes a major theoretical interpretation trend of social processes related to the AIDS pandemic (Farmer 1992).

[19] Abidjan, personal communication, author's translation ("*Le problème c'est pas l'allaitement, c'est les femmes séropositives*.").

[20] See footnote 4

one after another when medical recommendations request that one is chosen "for good" and applied without any variation. Women would also adapt the feeding pattern according to changing social contexts, which is not supported by PMTCT. They would set "risk reduction" when PMTCT claims "risk withdrawal," when they either used mixed feeding or were ready to re-start breastfeeding in case of a formula shortage. These hybrid patterns, which showed women's capacity and limits in adapting to their context, are not valued by the health system since they do not correspond to the strictly defined patterns that were validated by experimental clinical trials.[21] There, women's experiences reveal the rigidity of medical concepts, which lack the sensitivity to contexts that are empirically developed by women. Further studies in political science are necessary to understand how this lack of acknowledgement is, on this particular topic, related to social and gender status differences between women in Burkina Faso—who are poorly represented as a community force capable of social "transformation"—and scientists at the international level.

Shared decision making with fathers was advised by health workers, who acknowledge the need for fathers' psychological and material involvement to support mothers made vulnerable by the risk of HIV stigma; it may also result from defined gender roles inspired by western orientated patterns, which underlie UN agency recommendations for HIV counseling, implemented by heath workers in PMTCT programs. Before, mainly women provided care, assisted by grandmothers and elder women. Now, because they are afraid of a possible breach in confidentiality and rejection from the extended family, decision making is increasingly limited to couples, which subsequently means greater involvement from men. This focus on the couple, which also emphasizes sharing responsibilities equally between men and women and promoting rights of individuals among PLHIV whatever their gender as a means of protection against rejection, is also enhanced in some PLHIV organizations and publically demonstrated by their leaders.

Focusing on the parental couple or nuclear family and on the mother-child interaction rather than on extended family are preventive discourses that convey social models from western or global cultures. Whether instrumental, aimed at avoiding HIV-labeling by the extended family or intertwined with medical media and messages, these models have spread with the globalized AIDS culture conveyed particularly by NGOs and PLHIV associations. More than the "therapeutic citizenship" that has not yet developed in Africa in the field of PMTCT (Blystad & Moland 2009), contrary to other fields (Nguyen et al. 2007), this individualizing and nuclear pattern in family social organization, which also corresponds to a shift in gender roles, may be the social transformation brought about by the HIV pandemic through the prevention of HIV breastfeeding transmission.

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[21] From an epidemiological perspective, the overall reduction of milk intake should reduce HIV transmission.

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